

**THE ACADEMY OF HEALTH SCIENCES
U.S. ARMY - BAYLOR UNIVERSITY
GRADUATE PROGRAM IN HEALTH CARE ADMINISTRATION**

DEVELOPMENT OF A BUSINESS PLANNING HANDBOOK

GRADUATE MANAGEMENT PROJECT

SUBMITTED TO

THE FACULTY OF THE ACADEMY OF HEALTH SCIENCES

IN CANDIDACY FOR THE DEGREE OF

MASTERS IN HEALTH CARE ADMINISTRATION

BY

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INTRODUCTION

This graduate management project (GMP) focuses on the development of a business planning handbook for use by the various departments (clinics, ancillary services, inpatient units, administrative departments, etc.) at Wilford Hall Medical Center.

Conditions Which Prompted the Study

Wilford Hall Medical Center is under increasing pressure from all directions to be as efficient as possible with its vast array of resources. The health care industry is undergoing a metamorphic change. The 1980s and 1990s have seen the introduction and proliferation of managed care, capitation, integrated delivery systems, health maintenance organizations (HMOs), preferred provider organizations (PPOs), physician-hospital organizations (PHOs), and many other forms of competitive ventures that are designed to create cost effective, quality health care systems. At the same time, the Department of Defense (DOD) is in the process of rightsizing, usually resulting in downsizing, to meet the demands of the political and economic environment of the 1990's. As a component of the DOD's Military Health Services System (MHSS), the United States Air Force Health Service (AFHS), and in turn Wilford Hall Medical Center, are faced with several significant factors that will impact their ability to deliver health services. These factors include the risk of personnel reductions and severe financial budget constraints, major changes in the practice and delivery of health services both within and outside the MHSS, and a competitive environment where both civilian and other DOD health care agencies are vying for the opportunity to assume responsibility for our DOD health care-eligible beneficiaries. Wilford Hall Medical Center must meet the challenges of the 1990's and beyond by creating a cost effective, quality health care system that can compete within the health care market, while maintaining the ability to fulfill an expanding medical readiness role to meet the needs of the DOD and the AFHS. This can only be accomplished through proper strategic and operational planning and execution at the local and national level.

By virtue of its size and scope of services, Wilford Hall Medical Center is a major component of the AFHS. It is also a major consumer of AFHS resources. In years past, the AFHS has provided Wilford Hall Medical Center sufficient financial and personnel resources to meet its mission requirements. However, with the change in the political and economic climate, Wilford Hall Medical Center must prepare for this new environment. Wilford Hall Medical Center will be forced to make choices between various services or products and the level of effort in each. While these decisions will ultimately be made at the senior leadership level within the medical center, the information to make these decisions must come from the operational units.

In recent years, the AFHS has made strides to improve planning efforts through top-down initiatives directed at strategic planning. In 1995, the Air Force Surgeon General's office headed a team of over 80 personnel from units throughout the United States Air Force in preparing the Strategic Health Resourcing Plan (SHRP) Development Guide. The guide provides the framework for developing strategic plans at the local military health facility (MHF) level. Using the SHRP development guide, the men and women of Wilford Hall Medical Center developed their own SHRP in October 1995. The plan was Wilford Hall Medical Center's first attempt to directly associate strategic planning with the resources required to reach their tactical and strategic goals. The plan was put together through the hard work of many "champions" who undertook leading roles in researching and creating various aspects of the plan.

The SHRP established a baseline from which future planning will be accomplished. In 1997, two simultaneous efforts are being conducted that will help provide a strategic guide for Wilford Hall Medical Center to move into the 21st century. The Mission Support Plan (MSP) is a direct follow-on to the SHRP. The MSP will evaluate progress made since the SHRP was developed and provide the blueprint for the future. The switch from the SHRP to the MSP is more than just a name change; it is an evolution of a planning concept which will propel the MSP into a living document that will develop and change over time. The MSPs from each MHF will provide input for the AFHS MSP, which in turn will support the line functional area plans. The second effort is the development of the Program Guidance Letters (PGL). The PGLs are an

outgrowth of the reengineering/rightsizing effort at Wilford Hall Medical Center. As Wilford Hall Medical Center moves to reduce bed capacity and enhance ambulatory services, the PGLs are designed to provide general guidance for more efficiently using MHF resources. One component of the PGL is a requirement to develop a business plan for each product line. The PGL is currently in draft stage pending approval from the 59 MDW Commander.

Due to the size of Wilford Hall Medical Center, the preparation of the SHRP was developed at the macro level by the Board of Directors, with primary participation at the wing and directorate (two-letter) level (figure 1).

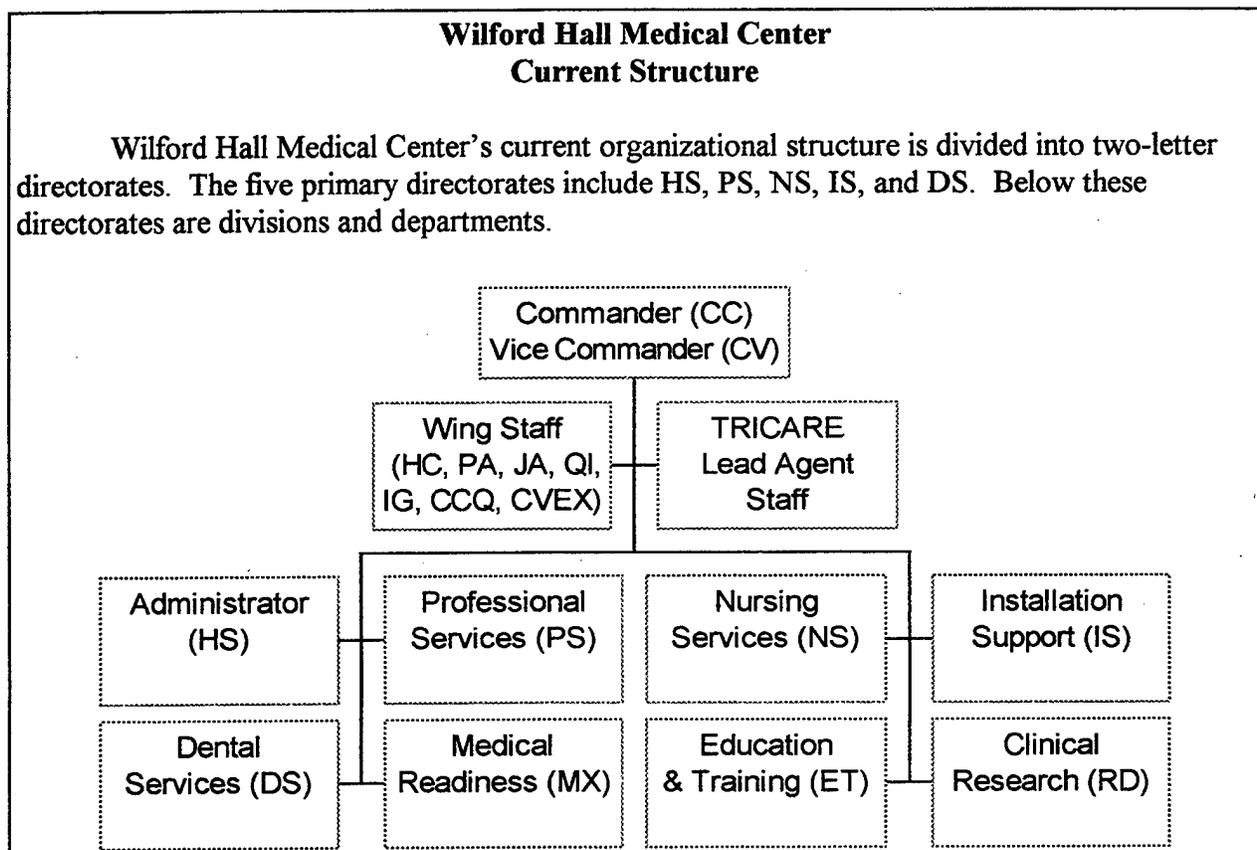


Figure 1. Current Structure of Wilford Hall Medical Center

As a "strategic" planning document, the SHRP was an important first step. The next step is to take the planning process down to the lowest operational elements of the organization.

In the current organizational structure, plans will be developed at the department level, with consolidation at the division and directorate levels.

Due to the proposed reorganization of Wilford Hall Medical Center, a look at the new organizational structure, the Objective Medical Wing (figure 2), is warranted.

In the objective structure, the lowest operational component is the flight or flight element, depending on the size and diversity of the flight. The primary emphasis of the planning process at the flight level is to identify the services offered, their associated costs, and how they align with the stated vision and missions of Wilford Hall Medical Center (below).

**WILFORD HALL MEDICAL CENTER
VISION**

“The “GO TO” 911 Healthcare Team”

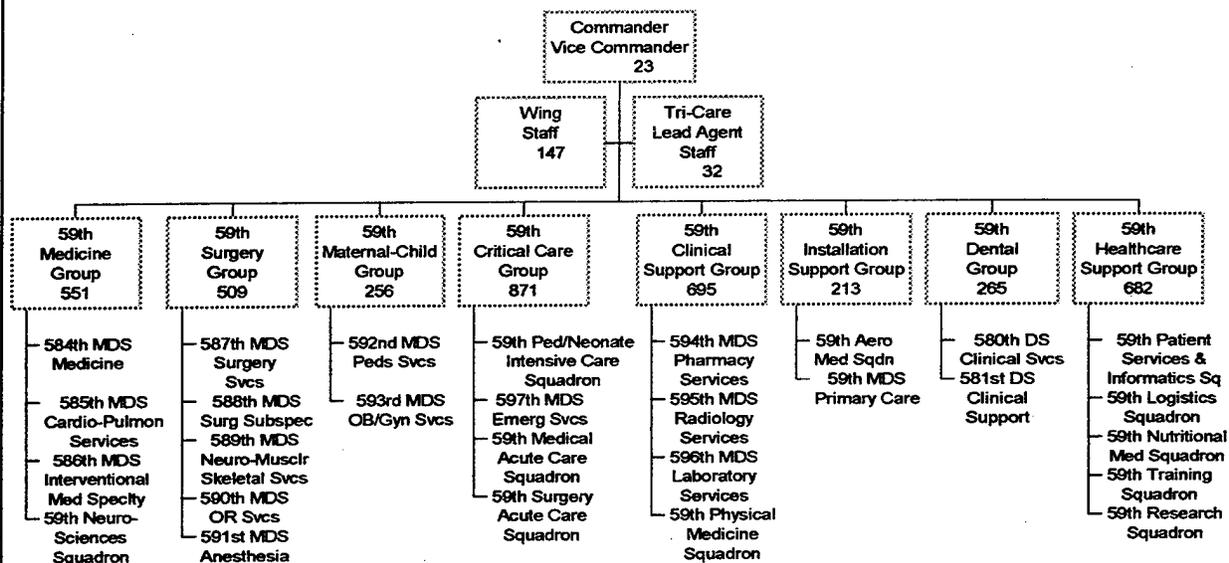
**WILFORD HALL MEDICAL CENTER
MISSION STATEMENT**

- ◆ *Readiness: Always ready to provide healthcare and deploy under the challenging conditions of worldwide contingencies to support global engagement.*
- ◆ *Peacetime: Building healthier communities by delivering compassionate, personalized healthcare.*
- ◆ *Education and Training: Support peacetime and readiness missions by providing the best military unique healthcare education and training.*
- ◆ *Research: Improving our peacetime and readiness capabilities through innovative research.*

Under the objective structure, each squadron will consolidate inputs from their flights and develop a “squadron” business plan. The “squadron” business plans, like the department plans, will define the units resources and outputs, conduct a competitive analysis, tie operational functions to readiness requirements, and establish priorities at the squadron level. The Groups

Proposed Organizational Structure Objective Medical Wing

Wilford Hall Medical Center has formally requested authorization to reorganize its structure into an Objective Medical Wing. The proposed Wing will be divided into eight groups, aligned primarily along product lines.



Each Group will be divided into Squadrons, and Squadrons into Flights. An example is shown below:

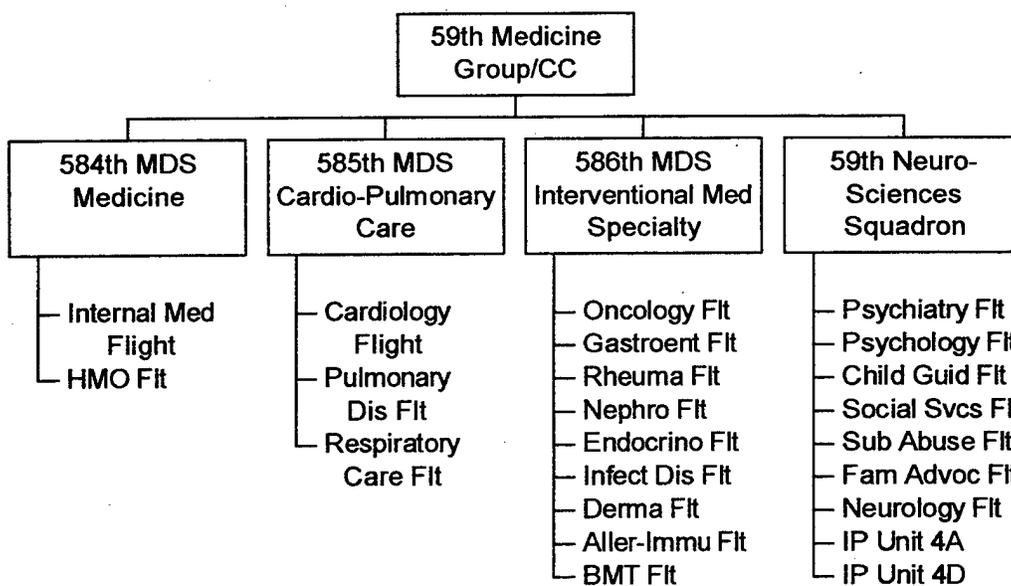


Figure 2. Proposed Structure of Wilford Hall Medical Center

will consolidate the "squadron" business plans. These consolidated plans will provide the framework for future strategic planning by the senior leadership at Wilford Hall Medical Center. Senior leadership can use this information for developing future goals, evaluating priorities, and determining resource allocations. These business plans will complement the SHRP/MSP with greater detail of the various products and services Wilford Hall Medical Center provides. Under either organizational structure, the purpose of the squadron/department business plan is to articulate the SHRP/MSP at the clinical level.

Wilford Hall Medical Center is a large, complex health care organization with a financial program of over \$369 million, a staff of over 4,300 personnel, and a medical center campus comprised of over 61 buildings that total over 1,900,000 square feet.

As the Air Force's premier health center, Wilford Hall Medical Center programs are wide and varied. A sample of the programs are identified below:

Graduate Medical Education	Primary Care (HMO)	Level IV Trauma Center
Clinical Research	Solid-Organ Transplant	Medical Readiness
World-wide AF Referral Center	Bone Marrow Transplant	Cardio/Thoracic Surgery
Neurosurgery	Plastic Surgery	Multiple Sub-specialties

It is safe to say that few people, if any, have a firm grasp on the total number of health care products or services Wilford Hall Medical Center provides. It is even safer to say that Wilford Hall Medical Center does not have a firm grasp on the cost of each product or service provided. As Wilford Hall Medical Center reorganizes to the objective structure, it will be up to the individual flights to articulate the products and services they provide, the costs of those services, and how they contribute to the missions of Wilford Hall Medical Center.

Statement of the Problem

The problem this graduate management project addresses is the lack of step-by-step guidance at the operational level for developing business plans. This project provides the leadership in each squadron/department a simple, systematic, yet flexible tool they can use to develop business plans. The development of business plans at the squadron/department level will greatly enhance the overall planning process at Wilford Hall Medical Center. The business plans will be a useful tool for both the individual squadron/department and the organization as a whole.

Literature Review

A great deal of printed literature is available on business plans, the planning process, and the need for planning at all levels of the organization. The term 'business plan' is open to numerous definitions. Lehman (1996) states that a business plan is a blueprint for a new line of business, product, or service. Lehman further states it can be useful for studying the potential of expanding or significantly changing an existing line of business. Fogelsonger (1995) also suggests the use of business plans for the introduction of new business lines, major purchases, and integration of existing services. Numerous articles concentrated on the need for business plans when an entrepreneur is just beginning a new business. It is clear that many authors only considered the business plan as a tool for change within an organization. Bennett (1994) and Furlong (1996) discussed business planning in a different context. They identify the strategic business plan as a significant tool in successful business development. Their emphasis is on clearly identifying where you are, reviewing the organizations current strengths, weaknesses, opportunities, and threats (SWOT), and then determining where you want to go and how to get there.

What is apparent in all of the literature is a consistency in approach for business plan development. Regardless of the purpose of the business plan, each author followed a very similar

list of core requirements: a clear mission statement or description of the business, market and competitive analysis (SWOT), a financial plan, operational needs, and an action plan.

Harrison (1994) identified the need to view the production of the business plan as a “means” rather than an “ends”. Figure 3 distinguishes the difference between the two approaches.

	A “means” approach	An “ends” approach
Philosophy	A journey	A destination
Focus	A process	A task
Shaped by	Leadership	Direction
Driven by	Needs of the organization	Needs of leader
Orientation	Largely outward looking	Largely inward looking
Dominant medium	The spoken word	The written word
Involvement	Wide internal/external	Narrow and largely internal
Concerned with	Opportunities	Threats
Seeks	Success	To avoid failure
Utility	Central→shapes action	Marginal→archive

Figure 3. Two Approaches to Business Planning (Harrison, 1994)

Harrison states that the ability to get planners to adopt the business plan as a means rather than an ends will determine if the plan becomes a living document or a document that is placed on the shelf to collect dust.

Many tools were introduced by different authors for approaching various aspects of plan development. The articles by Bennett (1994) and Furlong and Burns (1996) discuss the National Health System (NHS) in England as their base of reference for business planning. As a national program, the NHS provides a comparison of services provided by or through a government agency, much as the DOD does in the United States. Bennett encourages the use of the Ansoff Matrix as a tool to identify the customers served and the services offered. The Ansoff Matrix is a

basic matrix that allows a one-shot view of an entire service or department, reinforcing the concept of "a picture is worth a thousand words." Bennett believes the Ansoff Matrix is a useful tool for both planning and forecasting. Furlong and Burns provided a good overview of the strategic business planning process for a multi-specialty group practice. Their flowchart clearly articulates the process and the interrelationship among the various steps in the process.

Thompson (1996) describes the rapid changes occurring in the public hospitals in Hong Kong and the problems of adapting the business planning approach to the distinctive requirements of the public sector. He also discusses three dimensions for evaluating planning: incremental vs. developmental, reactive vs. proactive, and ends vs. means. His findings in this area support and expand those found by Harrison (1994).

In addition to the many articles reviewed, the resident reviewed numerous internal planning documents and guidelines to identify MHSS unique strategies and tactics based on resources available at the MHF. These documents are identified in the Methods and Procedures section below.

Purpose

The purpose of this graduate management project is the development of a tool; a handbook to assist squadron/department leadership in the preparation of business plans.

METHOD AND PROCEDURES

The resident developed the business planning handbook through the collection, analysis, and incorporation of material from numerous sources. The following sources of information were used in the process:

- The AF/SG Strategic Health Resourcing Plan Development Guide.
- The WHMC Strategic Health Resourcing Plan dated October 1995.
- The draft version of the WHMC Mission Support Plan.
- The draft guidance for the Program Guidance Letter.
- The Joint Commission on Accreditation of Healthcare Organizations Standards Manual.

- Review of business plans developed by various departments throughout WHMC. For example, the Surgery Department developed a strategic plan in 1996. Their lessons learned, sources of data, and planning process provided keen insight for the development of future plans.

- Material obtained from the literature review and business planning books.

The business plans have certain requirements that must be included. As a minimum, the plans will address the following areas:

- Goals and objectives.
- Role in medical readiness.
- Scope and level of patient care services.
- Staffing and space utilization.
- Customer assessment.
- Competitive analysis (strengths, weaknesses, opportunities, and threats)
- Financial analysis.
- Performance measures.

The handbook provides a suggested outline for the business plan. For each topic, the resident provides a methodology for development. Depending on the topic, a proposed approach, sources for information, examples, and other materials was provided as appropriate. The degree of flexibility allowed in each business plan to meet squadron/department specific needs will be established by senior leadership. The business plans will be flexible enough to give each squadron/department ownership of their particular plan, but standardized enough to allow consolidation and consistency at the group level.

THE RESULTS

The attached business planning handbook was developed by the resident and approved by the Wilford Hall Medical Center Administrator. The development of this 'how to' guide for business planning will significantly enhance the planning process at Wilford Hall Medical Center.

These operational plans are key to long-term strategic planning. As the DOD rightsizes, the future of Wilford Hall Medical Center will be determined, in large part, on its ability to provide cost-effective, quality health services. Well-developed and clearly written plans will help senior leadership articulate the many positive services Wilford Hall provides and strengthen its standing as the premier medical center in the United States Air Force.

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Strategic Health and Resourcing Plan. 59th Medical Wing, October 1995.

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WILFORD HALL MEDICAL CENTER

BUSINESS PLANNING HANDBOOK



**59TH MEDICAL WING
RESOURCE MANAGEMENT OFFICE
LACKLAND AFB, TEXAS**

APRIL 1997

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INTRODUCTION

The purpose of this business planning handbook is to assist each squadron/department at Wilford Hall Medical Center in the development of a strategic and operational plan.

This handbook provides the leadership in each squadron/department a simple, systematic, yet flexible tool they can use to develop business plans. The development of business plans at the squadron/department level will greatly enhance the overall planning process at Wilford Hall Medical Center. The business plan is a useful tool for both the individual squadron/department and the organization as a whole. This planning process will help the squadron/department leadership focus their efforts and align with the vision, mission and goals of Wilford Hall Medical Center. Under the current organizational structure, the business plans will be developed by each department and consolidated at the division and directorate levels. When the new objective wing structure is approved and implemented, each squadron will consolidate inputs from their flights and develop a squadron business plan. The Groups will consolidate the squadron plans. These consolidated plans will provide the framework for future planning by the senior leadership at Wilford Hall Medical Center.

This handbook is not intended to be the sole resource for plan development, nor is it rigid in its implementation such as a required format of the final plan. The handbook will provide a suggested outline for the business plan. Depending on the specific topic or subject, a proposed approach, sources for information, examples, and other materials will be provided as appropriate. Individual squadrons/ departments should create their own business plans to meet their own needs. The styles of different managers and the variety of products, services, and support functions do not allow for complete consistency among the squadron/department plans. The degree of consistency or flexibility in content and form is addressed where appropriate in the various subject areas. It is acknowledged each business plan must be flexible enough to allow adaptation based on the needs of each squadron/department and each squadron/department needs a sense of ownership of their particular plan. At the same time, certain areas must be standardized enough to allow consolidation and consistency at the group level.

The business plan should cover the following generic areas: the mission, budget plans, goals/objectives, patient volume, staffing issues, strategies to be achieved, and strengths/weaknesses of the department. This handbook will help you develop each area and think through the processes required to achieve a viable business plan. The final plan should provide the squadron/department with direction for the future, goals to meet, and plans of action to achieve these goals. Most importantly, the plan will challenge your squadron/department to take on new responsibilities and become more involved in current activities.

The business plan is not a one-time document to be placed on the shelf to collect dust once completed. It should be a part of an ongoing process of continuous quality improvement. Your first business plan will probably be your most difficult and you should not expect it to be perfect. Each periodic revision will help fine tune your planning process and move you closer to your strategic goals.

This handbook is a tool in development. Please forward any suggested changes or additions to the Resource Management Office so we may incorporate your input and increase the usefulness of newer versions of this business planning tool.

EXECUTIVE SUMMARY

The executive summary is the first chapter of your business plan, but the last part you write. Return to this section after completing the other chapters.

Summarize your entire plan and reflect your overall mission, values, and goals in a hard hitting, fact based format. The executive summary is just what it says. It should summarize the entire plan for busy staffs and decision makers. Be succinct and to the point. Every word in the executive summary is critical because it brings together all the long hours of thinking, planning, writing, and production invested in the business plan. The summary should stand alone. The reader should not have to know what's in the rest of the plan to understand the summary.

Briefly describe each of the following:

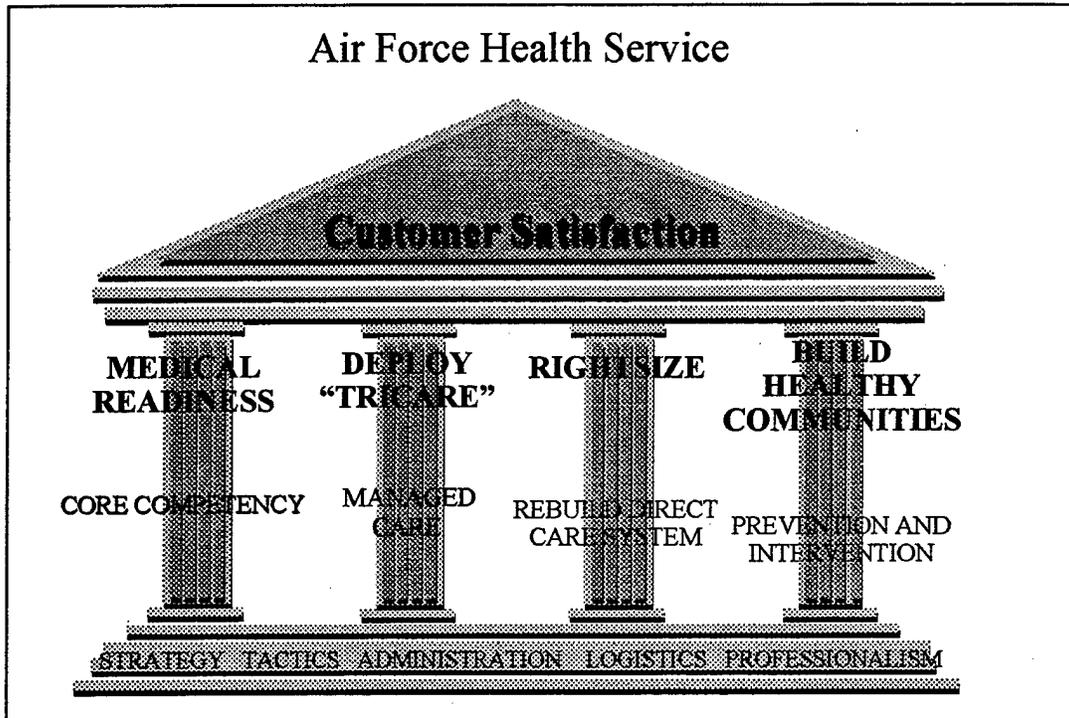
1. Clearly describe the current business operation, environment, standards of practice and how you envision the future and plan to operate. Demonstrate the linkage to the goals and priorities of WHMC, other plans, and resourcing requirements.
2. Discuss the major political, economic and legal influences, factors, and organizations that fashion your local healthcare market; include the clinical practices, policies, and programs.
3. Identify the key components of your strategy to increase or decrease your market share; include clinical perspectives on building healthier communities.
4. Outline your major thrusts to make your competitive strategy a reality to include managed care strategies and tactics, proposals to manage demand, and ways to capitalize on region initiatives.
5. Outline your major resourcing requirements from a tactical and strategic perspective and from an internal and external reinvestment perspective.
6. Outline how you will monitor and measure progress; include timelines.

HINTS: Although the first chapter of your plan, we recommend you write it last. It should:

- ◆ Summarize each chapter, highlight critical areas, and stand alone.
- ◆ Include a high level quantitative view to support your strategic vision.
- ◆ Include the preventive, building healthier communities, provider and nurse manager's perspective.
- ◆ Flow logically from the major parts of the plan.
- ◆ Reflect each part of the business plan: it may be the only part many of your key stakeholders will read.
- ◆ Serve as an outline for briefings and presentations about your business plan.
- ◆ Focus on both internal and external strategies and tactics.

STRATEGIC MANAGEMENT CONNECTION

The second chapter of the plan is dedicated to the linkage between the strategic direction of the Air Force Health Service (AFHS), Air Education and Training Command (AETC), Wilford Hall Medical Center (WHMC), and your specific squadron/department. This is your opportunity to show how and why the services you provide are important and what you plan for the future. Throughout the development and implementation of your business plan, you should consider the strategic initiatives identified by the Air Force Surgeon General as symbolized in the four pillars of the Parthenon in Figure 1.



The four pillars include Medical Readiness, Deploy TRICARE, Rightsize, and Build Healthy Communities. What is your squadron/department doing to advance these four strategic initiatives?

VISION AND MISSION

The development of a squadron/department level vision and mission statement is at the discretion of the individual squadron/department. You can develop your own vision and mission statements that align with and support those existing in the hierarchy above your squadron/department, or you can adopt the vision and mission statement of WHMC (or of your Group if one has been developed). Whether you choose to develop your own or to adopt the WHMC (or Group) vision and mission statements, you must clearly describe what your squadron/department is doing to support them. Establish a connection - a thread of continuity between your strategic direction (what you want to be) and your business plan (how you're going to get there). The most recent vision and mission statements are provided on page 4.

**UNITED STATES AIR FORCE
VISION**

“Air Force people building the world’s Most
respected air and space force...global power and
reach for America”

**AIR FORCE HEALTH SERVICE
MISSION STATEMENT**

- ◆ Expand, mobilize and deploy medical support for contingency operations world wide.
- ◆ Develop and operate a comprehensive and cost effective community based health care system.
- ◆ Promote health, safety and morale of Air Force people.
- ◆ Provide or arrange timely, high quality health care.

**AIR EDUCATION AND TRAINING COMMAND
VISION**

Building the World's Most Respected
Education and Training Organization...
Recruiting, Motivating, and Preparing
Quality Airmen for America's Air Force

**AIR EDUCATION AND TRAINING COMMAND
MISSION STATEMENT**

Recruits, accesses, commissions, trains and educates Air Force enlisted and officer personnel. Provides basic military training, initial and advanced technical training, flying training, and professional military and degree-granting professional education. Conducts joint, medical service, readiness and Air Force security assistance training.

**WILFORD HALL MEDICAL CENTER
VISION**

“The “GO TO” 911 Healthcare Team”

**WILFORD HALL MEDICAL CENTER
MISSION STATEMENT**

- ◆ Readiness: Always ready to provide healthcare and deploy under the challenging conditions of worldwide contingencies to support global engagement.
- ◆ Peacetime: Building healthier communities by delivering compassionate, personalized healthcare.
- ◆ Education and Training: Support peacetime and readiness missions by providing the best military unique healthcare education and training.
- ◆ Research: Improving our peacetime and readiness capabilities through innovative research.

GOALS AND OBJECTIVES

This section identifies your goals and objectives. Review the Wilford Hall goals and objectives [available in the WHMC Quarterly Management Summary (QMS) developed by the Planning and Analysis Branch, ext. 2-5110]. To the extent possible, align your goals and objectives with the broader medical center goals and objectives.

1. What are your short-term and long-range goals?

- ◆ Make sure your goals link to those of WHMC and to higher headquarters' corporate philosophy.
- ◆ Describe where you think you should be heading as you accomplish the goal (one example might be the role prevention plays in building healthier communities).

2. What key actions should take place? When? How? Where?

- ◆ These should have clear milestones established, responsibilities assigned, and within resource limits.
- ◆ Consider displaying your milestones graphically to include timelines, OPRs, and coordination.

3. Who are your goal, deployment, and implementation champions and what is the current status of each goal?

- ◆ Empower individuals and teams to begin moving closer to your shared vision.
- ◆ Describe environmental assessment of forces influencing your ability to meet the goal and objectives.
- ◆ Discuss gaps between current and future capability.
- ◆ Identify key result areas you think the facility should focus on.
- ◆ Describe plans and timeline to complete the goal review process.

ROLE IN MEDICAL READINESS

On 13 December 1996, Lieutenant General Roadman, the Air Force Surgeon General (AF/SG), addressed the medical service in a video-teleconference that was broadcast to medical personnel Air Force-wide. The AF/SG clearly articulated the direction he plans to lead the Air Force Health Service (AFHS). The AFHS will concentrate on good business practices and fulfilling our medical readiness missions. Our medical readiness function will focus on the Air Force's post-Cold War strategy of "Enlarge and Engage." General Roadman said this focus is a necessary condition for us to be in uniform. If we look like Humana or PacifiCare, there is no reason to be in uniform. "Enlarge and Engage" will mean more missions in the area of humanitarian assistance, operations other than war, forward surgical teams, and critical care aeromedical transport teams. These missions are in addition to our current medical readiness unit type code (UTC) commitments. Wilford Hall Medical Center's very existence depends on our medical readiness capabilities. Major General Carlton, 59th Medical Wing Commander, stated "if we are not ready in a moments notice, we will not be invited. If we are not invited, we will go away." It is clear the AFHS will reduce in size. Support services that are not required for medical readiness and are not cost efficient will be eliminated or privatized. With this in mind, chapter three should identify your squadron/department's role in medical readiness.

Consider the following questions as you identify your role:

1. How many of your staff members are assigned to a mobility slot? (Attach listing)
2. What slots do they fill? How often/long are they deployed?
3. What allowances do you make in your schedules for medical readiness training?
4. Which disaster teams do your staff members support?
5. What is your squadron/department's role in planning disaster exercises?
6. What can your department do to become more involved in medical readiness?
7. What will it take for your department to become more involved in medical readiness?

Note: Proper identification of readiness requirements are essential for the BCA process and are discussed further in the Resources Chapter.

CUSTOMER ASSESSMENT

Customer assessment/surveillance analyzes your market in terms of your current and potential customers. It is to ensure your plan, and ultimately your actions, are customer-focused.

1. Who are your current and potential customers (define by service line)?

- ◆ Identify your current customer mix to include transient and seasonal customers.
- ◆ How far do your customers travel to get to you? Where do concentrations of your customers live?
 - ◆ Consider the four geographic service areas:
 1. 40-mile catchment area.
 2. 200-mile geographic radius.
 3. Regional area (Region VI).
 4. National (Global) referral network.
- ◆ Do your customers' lifestyles affect their "purchasing" behavior? What are their health risks, lifestyles?
- ◆ Are your customers' demographic, age, gender, and race distributions affecting their healthcare decisions?
- ◆ Are there healthcare purchasers in your community that control certain groups (e.g., Veteran's Administration, nearby MHF, etc.) you might attract?
- ◆ What customers have health insurance and what coverage do these policies offer?
- ◆ What medical conditions and risk factors are inherent to our beneficiaries? Enrollees? Target customers?

HINTS:

- ◆ Check traditional data sources for determining who your customers are (e.g., ADS, CEIS, CHCS, CMIS, EMPRS III, ICDB, patient surveys, appointment logs, patient records, etc.). (A list of computerized data sources/management systems is available at Appendix A.)
- ◆ This information can be obtained by zip code. Take into account the numbers coming from in and out of your catchment area to determine if trends are increasing or decreasing. Determine if new regional referral patterns and establishment of specialized treatment services, base and service closures, natural disasters, changes in the Aeromedical Evacuation system and other imposed factors may change what you have experienced in the past.
- ◆ To effectively understand your customers' healthcare purchasing behavior, you must either ask your customers or segment your market (grouping your customers by the causal factors that determine their purchasing decisions). There are several ways to segment the market to include demographic (age, risk factors, sex, buying power, occupation, education, race/nationality, family life cycle), geographic (counties, cities, neighborhoods, climate, terrain, population density, market density), behavioristic (amount of usage, type of usage, brand loyalty, benefits sought), psychographic (social class, lifestyles, habits), and health status.

2. What do your customers want from you? [This is the most important piece of your plan. You must understand your destination (meeting your customers' expectations) before you can plan your journey or the resources you need to get there. Set your assumptions aside and hear what your customers are saying.]

- ◆ What do our customers expect from us?
- ◆ Can you list your actual enrollees from the MCS contractor's database? Primary Care Enrollment? Civilian primary care provider enrollment? Realistic in meeting your enrollment goals?

- ◆ What differences exist between what your customers want and what they actually need? How can we educate them about those differences?
- ◆ Do you know what your upper limit for enrollment is? Realistic? When to say NO when you have to? When to focus on your enrollees' needs vs. non-enrollees?
- ◆ Are there gaps between your expectations and what they perceive they get?
- ◆ Are we redesigning our services to meet their expectations?
- ◆ How do your customers perceive us relative to our competitor/partners?
- ◆ Why do some of your potential customers use other sources of care?
- ◆ Would they be willing to utilize our network, even if it meant more travel time?
- ◆ Are they willing to access our services? Is it the easiest in the world?

COMPETITOR/PARTNER ANALYSIS

WHMCs primary competitors and partners in San Antonio are identified in the 59th Medical Wing Mission Support Plan (MSP), along with a SWOT analysis for each. At the squadron/department level, you should identify the primary competitors for your product line. They may be some of the same as identified in the MSP, or they may be different. They could be other military MHFs, a civilian organization downtown or possibly some other competitor. Second, identify your partners who are in business with you. Note, your competitor could also be a partner. Third, develop what we call SWOT charts for your competitors, partners and for your squadron/department. A SWOT chart is used to identify Strengths, Weaknesses, Opportunities, and Threats. Examples of a SWOT chart can be found in the MSP. When complete, the charts will provide a good competitor/partner analysis.

1. Who are your potential competitor/partners? Can you make a potential competitor/partner a business partner? Competitor/partners to consider are:

- ◆ Established health plans, regional or national.
- ◆ Independent healthcare entities that may affiliate to compete or can compete without affiliation.
- ◆ Other federal agencies (MHF, Veteran's Administration, Public Health Service).

2. What are your competitors'/partners' strengths and weaknesses? Consider their:

- ◆ Reputation. In a mobile community such as the military, many people rely strictly on reputation to make healthcare purchasing decisions.
- ◆ Ability to attract customers. Do the competitor/partners have strong marketing programs? Do you have a strong marketing plan?
- ◆ Customer satisfaction. Are the current customers pleased with the service?
- ◆ Community awareness. Are your customers aware of alternative plans? Are potential customers aware of our services?
- ◆ Cost. Are the competitor/partners more or less expensive than the cost structure under TRICARE?
- ◆ Benefit package. How do they compare to TRICARE?
- ◆ Financial. Are they financially stable?
- ◆ Providers. What does their network look like?
 - ◆ Specialty mix.
 - ◆ Geographic distribution.
 - ◆ Affiliated hospitals.
 - ◆ Affiliated pharmacies and other ancillary services.
- ◆ Quality. Is the quality of care, whether subjectively or objectively measured, superior?
- ◆ Choice. Do patients get to choose providers and hospitals?
- ◆ Access. Is their appointment system easy to use? How long must you wait before securing an appointment and seeing the provider? Do they meet or exceed the standards in the Managed Care Support Contract? Do you meet or exceed the standards in the Managed Care Support Contract?
- ◆ Referrals. Can patients self-refer to specialists?
- ◆ Amenities. What do their facilities look like? What "bennies" do they offer?

HINTS:

- ◆ Read your enemy's book: get and study your competitor/partners' marketing literature. If feasible, interview former patients.
- ◆ Review a copy of the National Directory of Health Plans and use for analysis purposes. A copy is available in the reference section of the WHMC Medical Library.

- ◆ Attend a major employer's health fair and talk with your competitors'/partners' representatives. - Use CHAMPUS information sources, RCMAS, CMIS, etc.
- ◆ Review Federal Employee Health Benefits Program packages.

3. How much of my market does my competitor/partner (another MHF, Veteran's Administration, Public Health Service) have? How much excess capacity do I have? What can/should I absorb?

- ◆ Look for indicators, standards, and benchmarks. National ratio of population to provider comparison? Occupancy rates compared to a standard? CHAMPUS claims reports?
- ◆ How many customers use your services and how many use others? Why?
- ◆ What percentage of government funds are spent by the direct care system and by CHAMPUS in your market? (Available in CEIS and from the managed care office.)
- ◆ What are the direct care and CHAMPUS percentages by service line? (Available in CEIS and from the managed care office.)

SCOPE OF CARE

Develop a defining statement that summarizes the specific services provided. Generally describe what level of service is provided.

- ◆ Are all procedures and diagnostics within a service or specialty available or is just basic, initial care provided with more complex cases referred?
- ◆ Is care provided to all age groups or are some (e.g., pediatrics) cared for or referred elsewhere?
- ◆ What key services are not provided?

HINT: This information may be duplicative of information provided in you mission statement or customer assessment. The idea is to clearly define the services (mission) of your squadron/department. Defining Scope of Care is a JCAHO requirement and may already be clearly spelled out for your department. Defining the level of service should consider the following:

- ◆ Types and ages of patients served.
- ◆ Methods used to assess and meet patients' care needs.
- ◆ Scope and complexity of patients' care needs.
- ◆ The appropriateness, clinical necessity, and timeliness of support services provided directly or through referral contacts.
- ◆ The availability of necessary staff.
- ◆ The extent to which the level of care or service provided meets patients' needs.
- ◆ Recognized standards or practice guidelines, when available.

COMPETITIVE STRATEGY

Developing a competitive strategy is essential to your success. This is where you decide what you are going to do that will make your customers choose you instead of your competitor/partners. Take another look at the goals you developed. Make sure your actions are in line with your words.

1. You must detail your strategy and the actions you will pursue to attract and retain your targeted market segments. Consider these three competitive strategies:

- ◆ Least Cost. TRICARE offers a significant cost advantage compared to most civilian health plans. Care provided at the MHF is also lower than seeking civilian health care through the TRICARE contractor. Depending on the status of the sponsor, there will be no or low enrollment fees and copayments. Obviously, consumers favor purchase options with little or no out of pocket expense as long as quality and access remain high.
- ◆ Differentiation. This is what your customers believe is different about you as compared with your competitor/partners. A differentiation strategy for healthcare may be aimed at: perceptions of quality, extremely good service, brand identity, convenience, no cost at MHF.
- ◆ Focus. A combination of Least Cost and Differentiation.

2. Considerations:

- ◆ Who are your Primary Care Managers (PCMs) and how many members will enroll in the MHF?
- ◆ Consider weekend or evening clinics or services?
- ◆ Have you established an access standard equal to or greater than your toughest competitor/partner? Your TRICARE contractor?
- ◆ How many enrollees will be needed to maintain GME or to maintain a cost effective bed occupancy rate? Meets the level and scope of care?
- ◆ Do you have an appointments function and policy targeted for all categories of beneficiaries? Enrollees or non-enrollees?
- ◆ What population do you need to support WHMC specialists?

HINT: This section is the culmination of everything you have done to this point. If you have done a thorough job with your market assessment and competitor/partner analysis, this chapter should not be difficult to write. Be creative in generating strategies you might use. Some strategies and tactics may emerge by reviewing your market assessment and paying particular attention to your customer segments and your product service line (DRG, CPT-4, APG procedures, etc.) profitability. The following examples are used at WHMC or elsewhere:

- ◆ Health promotion program
- ◆ Internal partnership to contract conversion
- ◆ Demand management services
- ◆ One-stop fitness & wellness center on base
- ◆ Focus on recapture of some high cost, high volume, high variation DRGs/CPT procedures
- ◆ Expansion of services
- ◆ External resource sharing
- ◆ VA sharing agreement
- ◆ New clinic service
- ◆ Base/Squadron CC desires
- ◆ Women's health program
- ◆ Pediatric screening
- ◆ Service closure

BUILDING HEALTHIER COMMUNITIES

A core competency of healthcare systems is the improvement of your community's health status. Successful health improvement strategies, whether in the workplace, the home, or the healthcare environment, strive to redirect traditional disease-based reactive care towards a proactive, prevention-based healthcare system. It is imperative that MHFs have a solid, well-financed, and future oriented program in place and integrated with community efforts to capitalize on the effective use of healthcare resources. The MSP contains a good outline of WHMC's programs designed to build healthier communities. Each squadron/department should look at what they are doing to support and/or enhance WHMC's programs.

1. What prevention-oriented and team-based strategies to improve the health of your population are you developing?
2. What are the top five causes of death or injury in your population? Are they preventable, and do you have a plan for reducing/preventing them?
3. In what ways have you focused on the production of health as opposed to the production of health care interventions? Are your incentives still volume-based, or are other measures used?
4. Current health care delivery systems require us to build linkages to the community and develop preventive health programs. Major health plan proposals should include:
 - ◆ Initiatives to proliferate healthy lifestyles through health promotion, preventive health, injury prevention, and measure their outcome.
 - ◆ Proactively seeking out best corporate business practices in disease/injury prevention and incorporation into MHF business strategies.
 - ◆ Initiatives for beneficiaries to reduce alcohol abuse, engage in aerobic exercise three times per week for at least thirty minutes, and to eliminate smoking are sound investments to pursue.

HINTS:

- ◆ Key linkages can be broken down into the following categories:
 - ◆ Training/Education: schools - military education/training, metrics, information technology.
 - ◆ Resources: metrics, health societies (ACS, AHA, etc.), workers compensation rates, managed care/provider links, pharmacy services, resource managers, line buy-in, family support center, universal service (rated & non-rated), civilian public health, civilian hospitals, research organizations, sister services, lead agent, consumer center, retirees, primary care manager, base agencies, wing CC, AAFES/DECA, objective medical wing, clubs, volunteers.
 - ◆ Services: schools, community, civilian public health, clubs, scouts, civilian hospitals, base agencies, AAFES/DECA, resource managers, lead agent, acquisitions, media, General Services Agency.
 - ◆ Regulatory Agencies: lead agent, DoD, AFIs, AFD, unions, GSA, NRC, OSHA, EPA, NIOSH, JCAHO, GHAA, state regulatory agencies.
 - ◆ Consumer: universal service, wing CC, readiness, youth center/child care, eligible beneficiaries, pharmacy, lead agent, line buy-in, civilian personnel, sister services, contracting activities, objective medical wing.
- ◆ Incentives and programs should be considered to help focus on building healthier communities at the organization and individual level. They are broken down by major category:
 - ◆ Finance Incentives: a portion of third party collections go directly to generating clinics, partnership with insurance companies, manpower & funding to support prevention.

- ◆ Career Enhancement: OPR, EPR, awards, medals, AFIT, programs for excellence.
- ◆ Education and Training: education wellness work force, CME, TDY, AFIT, telemedicine use for CME, recruit talent for teaching/OTS, permissive TDY.
- ◆ Wellness Activities: professional and training instructors, healthy habit awards to patients, active duty time off to participate, bonus points/green stamps/tours programs, exercise classes -- accessible/on location, health and wellness centers, immunization activities, fun activities, people place/family affairs, purchase equipment for health functions, youth involvement/awards, rewards for not missing programs/appointments, spouse/retiree incentives, invest in self-care programs, self-care books and materials.
- ◆ Improved Commander Awareness: Healthy People 2000, squadron/department information, compensation costs, outcome information, get rid of disincentives.
- ◆ Performance: provider report card, specialty pay, dollar award for individual, Air Force Suggestion Program.

5. Are you leveraging your resources? Being a good neighbor? Sustaining readiness and operational support? Have a proposal? Refined previous proposals?

- ◆ Develop investment proposals that contain key linkages between resources, services, training and education, regulatory requirements, and consumers.
- ◆ Proposals should identify implementation and cost-benefit analysis strategies based on the assessment of risk and hazards. Incorporate indirect costs into your analysis (e.g., lost duty time, compensation, etc.).

TRANSITIONING FROM MANAGING PROVIDERS TO MANAGING DISEASE

If our healthcare system is unsuccessful in preventing disease or injury, appropriate strategies must be developed to make the most efficient use of our resources by managing disease using quality, customer sensitivity, and market- driven factors as guides. Merge the best business practices with the best medical practices to develop a health care plan. Once your assessment is complete, you're ready to decide on a service mix and strategy which optimizes health care delivery.

1. What consumer illness burden or demand reduction strategies (and resourcing requirements) are you developing to manage disease in your local community?

- ◆ Medical Self-Care
 - ◆ Self-care programs
 - ◆ Disease/condition management
 - ◆ Focused clinical interventions
 - ◆ Triage, health advice services
 - ◆ Tele-management teams
 - ◆ Patient education/health empowerment strategies
- ◆ Organizational: Need to resource outpatient/community-focused health care.
 - ◆ Get nurses into outpatient areas.
 - ◆ Get tertiary prevention in outpatient areas due to illness orientation.
 - ◆ Example metrics: bed days vs. salary of staff, cost of supplies, FTE's per occupied bed day.
- ◆ Resourcing
 - ◆ Fund systems support, integrate with current systems.
 - ◆ Fund HAWCs and wellness programs with adequate space/facilities.
 - ◆ Managed Care Support Contract optimization, personnel requirements to run programs, resource sharing.

2. What is your plan for focusing on the right care, at the right time, at the right point of service, and in the right sequence?

- ◆ Are provider and nurse manager's perspectives being considered in the process?
- ◆ Are you and your staff actively involved in the utilization management process which should be designed to improve system performance, stimulate bi-directional accountability, facilitate resource efficiency, and stabilize cost through utilization review, case management, and discharge planning.
 - ◆ Articulate your short-term and long-term strategies and the problems associated with inefficiencies or abuse. These include institutionalized mechanisms such as strong utilization review and provider involvement.
 - ◆ Consider the human toll of unnecessary procedures and protecting your MHF from the financial costs of inefficient medical treatments and services.

3. Have you initially focused on the most common, most prone to develop complications, or most resource intensive diseases in your population? Optimize workload and manage demand between CHAMPUS and Direct Care settings: reengineer major disease groups.

- ◆ Focus on high cost, variation, high volume - top 10 procedures and what you do best.
- ◆ Plan the changes you want to make by service line and specify volume; evaluate capacity.
- ◆ Consider potential of third party collections for certain procedures.
- ◆ Review supplemental/cooperative trends by test, service, provider, volume. . . look for other alternatives.
- ◆ Estimate the impact of STSs, transfer payments.

4. Are you focused on the best opportunity for improvement in quality (including processes), customer service, or efficiency of resource utilization?

- ◆ Does your strategy forecast the future environment to assess impacts of emerging technology? Evolving concepts of care? Probable impacts of changing clinical paradigms?

5. Which product line (e.g., adult primary care/aerospace medicine, women's health, pediatrics, etc.) and capabilities packages (e.g., providers, support staff, equipment/supplies, access to care settings, training, facilities, systems) have you developed to support your competitive strategy? Aligned with product lines and services? Seamless continuum of care (e.g., prevention through rehabilitation, ambulatory care alternatives, greater patient involvement)? Do they help build a healthy community? Metrics? Benchmarks?

- ◆ Of these services, which can you make/deliver more profitably and more efficiently? How can they be optimized?
- ◆ Are there services that you presently buy now that you could make profitably/ more efficiently in house?
- ◆ Do you have services that should be outsourced due to lower cost?
- ◆ Do the services identified above support the AFHS Strategic Plan?
- ◆ Develop tactics to reduce use of expensive emergency rooms or inpatient units: can you turn fixed costs into variable costs or reduce costs in general?
- ◆ Look at per 1000 rates such as cost per eligible or other numerators.
- ◆ Check out and trend your ancillary utilization rates by service, provider, test, diagnosis, diagnostic tests (such as MRIs), or other procedures.
- ◆ Review diagnoses not sufficient for admission and develop a more cost effective setting.
- ◆ Set up a practice guideline committee for education and implementation purposes; consider purchasing from an external source due to long lead times to develop.
- ◆ Critically evaluate inpatient procedures for the potential to be performed on an outpatient basis.
- ◆ Consider the potential for case management to be applied in the outpatient setting for high risk groups.
- ◆ Are your mental health providers seeing cases that could be handled by other base counseling resources such as the Chapel or Family Services?
- ◆ Do you need to begin home health services? Do you need to buy them?
- ◆ Streamline process, reduce redundancy.
- ◆ Identify regional telemedicine initiatives and applications.

6. Are you developing optimal service mix regardless of setting (e.g., CHAMPUS, TRICARE contract, other referral center)?

- ◆ Does your service mix and managed care strategies and tactics include proposed investment opportunities, savings potential, incentives, reinvestment plan, and infrastructure and throughput improvement proposal?
- ◆ Does your strategy include activities and policies designed to influence and change customer behavior patterns?
- ◆ Understand your MEPRS expenses.
 - ◆ Amount spent is not necessarily equal to cost of care; MEPRS includes fixed and variable costs; does not include MILCON costs.
 - ◆ Include all supplies; some may not be accounted for in MEPRS extracts.
- ◆ Understand CHAMPUS and authorized CHAMPUS payment procedures.

- ◆ Classified by location, includes labor and non-labor rates, adjusts labor to location; should include professional fee factors.
- ◆ Many services default to billed services.
- ◆ Consider/reassess resource sharing/support agreements.
- ◆ Consider joint service/MHF projects to include DoD/VA sharing agreements and initiatives.
- ◆ Take a team-based approach to a make-versus-buy situation.
 - ◆ Determine if the concept is worth pursuing and sound; will it be of high value?
 - ◆ Determine the format and approach to your study; is there a specified one?
 - ◆ What information is available? Chances are it won't be perfect: may need a workaround.
 - ◆ Level of accuracy needed? Confidence in the data? Consistent? Sellable?
 - ◆ Determine the factors bearing down on the problem.
 - ◆ Don't forget ancillary support, minimum staffing levels, equipment and facilities requirements.
 - ◆ Did you get a cross functional clinical perspective? Buy-in?
- ◆ What tools and methods do you have? Any already established? Is what you developed traceable? Auditable? Benchmarks established?
- ◆ Are the results packaged and marketable? Will it aid the decision maker?
- ◆ Assess alternatives for contracting with health care providers.

HINT: Clinical management practice teams, provider and nurse managers must play a vital role in strategic planning. . . . are they? Many tools and methods exist to help you evaluate your service mix. Take time to critically evaluate your services, do it in light of your competitive and customer focused strategy and facility and higher headquarters' goals.

- ◆ Cost management strategy development at the group, squadron, and flight levels.
- ◆ Clinical Practice Pattern Development module of the Strategic Resourcing tool.
- ◆ Practice guideline development to include educational and training programs.
- ◆ Provider profiling development and practice pattern monitoring and evaluation.
- ◆ Feedback to strategic resourcing team on the local medical market in terms of quality and reputation of the institutions.
- ◆ Determine right mix of human resources using strategic resourcing tool/other benchmarks:
 - ◆ Primary care managers versus other providers and physician extenders.
 - ◆ Other professionals and technicians and relative skills.
 - ◆ Other.
- ◆ Measurement methods of product line performance to include technical outcome, service, access, cost, leadership, system-wide, and health status.

7. What is your reinvestment strategy? Is it tied to the resources section and integrated with the managed care support contract? Incentive program? Retraining program?

8. Are you looking at your services as a health care production function (HCPF) and devising competitive strategies for cost containment? Looking at throughput? Profit (revenue minus expenses)?

- ◆ Concept based on health care economic notion that a HCPF exists in many forms and in any health care setting.
 - ◆ HCPF is the technical relation between the output (health outcomes) of a service (procedure, admission, visit, other) and the input (resources) used to produce it. [ex: If the output were visits or inpatient procedures, then the combination of inputs used to produce the output may be the numbers and types of personnel (FTEs) utilized, medical supplies consumed, ancillary

(lab, x-ray, scripts, other) support used, meals served, surgical suite minutes consumed, equipment maintenance performed, etc.]

- ◆ Goal is to determine the least cost combination of inputs required to produce the same or increased level of output without sacrificing quality or access.
 - ◆ Manage and/or reduce utilization of some inputs to attain the optimal and minimal inputs required to produce the maximum output.
 - ◆ More productively use the combination of existing inputs through process improvement techniques and practice guidelines.
 - ◆ Change or substitute the mix or types of inputs to achieve the same or increased level of output (e.g., part-time nurse matched to projected census versus full-time staff).
- ◆ HCPF data and information can be derived from existing information sources and placed in a format suitable for further development and analysis.
 - ◆ MEPRS is the source of data and information reported in Statistical Assignment Statistics (SAS) and Expense files for any given inpatient and outpatient service.
 - ◆ RCMAS will allow the health care analyst to download inpatient procedures for a corresponding MEPRS account code: reports can be developed to get individual/total cases and transferred to a spreadsheet for further analysis.
 - ◆ Method of analysis integrates existing data and performs straight forward calculations to help the health care analyst draw conclusions and take action (or non-action) accordingly. A service (inpatient or outpatient) or MEPRS account is identified for analysis purposes.
 - ◆ The output or outcome measure is identified (e.g., fewer admissions/visits/procedures, decreased LOS, etc.)

RESOURCES

This section matches available/expected resources (staff, facilities, funds, medical equipment and systems) with your planned operations.

1. Staffing/human resources management.

- ◆ Provide summary of assigned versus authorized personnel. (The WHMC Quarterly Management Summary (QMS) provides good examples of a proposed format. Copies of the QMS are available through the Planning and Analysis Branch, ext. 2-5110.)
 - ◆ List officer and enlisted personnel assigned versus authorized by specialty and workcenter, projected vacancies, and summarize projected requirements (place details in appendix); identify any issues and write narrative if difference between assigned and authorized is 15% or greater.
 - ◆ List assigned versus authorized civilians by specialty and workcenter, and summarize projected requirements (place details in appendix); identify any issues and write narrative if difference between assigned and authorized is 15% or greater.
 - ◆ List by contract all contract providers and other contracted personnel by workcenter and summarize projected requirements; state if there are opportunities for conversion.
 - ◆ Identify GME residents assigned versus authorized by specialty; identify any issues and write narrative if difference of 15% or greater.
- ◆ Identify disconnects between assigned versus authorized staff with emphasis on major revenue generators, specialists and generalists; discuss overages and shortages.
- ◆ Address the results of the Strategic Resourcing Portfolio (SRP) and the impact of establishing staff authorizations based on these results. (Contact the Planning and Analysis Branch at ext. 2-5650 for further explanation of the SRP.)
- ◆ Discuss referral in and out workload patterns affecting staffing requirements to include impacts/opportunities with Specialty Treatment Service (STS) establishment in the region and other service mix changes (closure, start-up, expansion) affecting referral in/out workload changes.
- ◆ Address plans to optimize provider services by establishing an appropriate support infrastructure, flex time, etc.
- ◆ Address potential for staffing efficiencies through joint ventures like WHMC/BAMC integration, DoD/VA sharing agreements, TRICARE resource sharing/support agreements. (For more information on sharing agreements, contact the Managed Care Division at ext. 2-6154.)
- ◆ Address plans to add, close, increase, or decrease scope of service provided resulting from application of the Business Case Analysis (BCA) model or other analysis to include impact on GME, TRICARE bid price adjustments, contracting, readiness requirements, and resource sharing/support agreements. (The BCA model may or may not be suitable for your situation. Contact the Planning and Analysis Branch at ext. 2-5650 for more information.)
- ◆ Determine and support/justify optimal staffing mix of military, civilian, and contracting personnel.

HINTS:

- ◆ Do your personnel need more management skills to operate in a new environment?
- ◆ Are you using your professional healthcare administrators to the squadron/department's best advantage?
- ◆ Do you have personnel qualified to do things they are not doing?
- ◆ With the support of your provider and nurse manager's team member input, determine the right mix of human resources to include: generalists versus specialists, nurse practitioners and specialists, physician assistants, other professionals, technicians and administrative support.

- ◆ Compare your manpower requirements to other standards (provider/specialty to population ratios) such as: New England Journal of Medicine, local competitor and lead agent recommendation, Health and Human Services office of prepaid healthcare provider to population ratios. (Contact the manpower office at ext. 2-3817 for assistance.)
2. Physical plant/master facilities planning. (For assistance in defining requirements and available space, contact Facilities Management at ext. 2-7171. MCI 32-2 provides general guidelines.)
- ◆ Quantify requirements for inpatient and ambulatory functions.
 - ◆ Calculate space requirements based upon DOD criteria.
 - ◆ Identify any construction requirements to increase productivity in the clinics. Initiate AF Form 332.
 - ◆ Identify any needs for furniture and initiate furniture request package to MEMO.
 - ◆ Identify any interior design or finishes upgrades to improve appearance. Initiate AF Form 332.
 - ◆ Identify methods/proposals to optimize space.
 - ◆ Identify any buildings of opportunity and associated issues.
 - ◆ Identify requirements to run evening and weekend clinics and services, if applicable.
 - ◆ Identify any current or projected impact from rightsizing or the stand-up of the Objective Medical Wing.
3. Financial planning.
- ◆ Begin by identifying and analyzing your financial resources. Appendix B provides a few example formats for various ways to review your financial and personnel resources. Displaying your resources in various formats will create a visual picture that will enhance your planning and decision making. (For assistance in identifying financial resources, contact the Budget Branch at ext. 2-5593.)
 - ◆ Develop a tactical business plan for current budget year closeout and execution distributions.
 - ◆ Explain how you will meet the demands of your customers under budgetary constraint.
 - ◆ Keep in mind your strategic vision to support the following year or next several years.
 - ◆ Address resourcing implications associated with plans to add, close, increase, or decrease scope of service provided.
 - ◆ Review referral in and out workload patterns affecting resourcing requirements.
 - ◆ Review most frequently referred supplemental/cooperative care expenditures.
 - ◆ Review use of regional contracting initiatives to decrease costs.
 - ◆ Review top 10 high cost pharmaceuticals prescribed and drug utilization plans.
 - ◆ Will you have the money you need to achieve your strategy?
 - ◆ Project revenue from O&M funds, DoD/VA/TRICARE sharing agreements, third party collections, transfer payments.
 - ◆ Project expenses for operations, capital improvement, what you hope to spend in other procurement.
 - ◆ Other sources of income or revenue.
 - ◆ Develop a plan of how you plan to increase each of them where applicable and focus on reinvestment opportunities in the third party collection program; illustrate billed versus collected trends; state how you plan to optimize collections in your section.
 - ◆ Develop plans to implement and monitor transfer payments to include development of workload baseline.
4. Resource sharing/resource support proposals.
- ◆ Review current agreements; analyze areas of concern and suggest improvements.

- ◆ Consider option of sharing agreements when addressing resource implications associated with plans to add, close, increase or decrease scope of service.
- ◆ Target prevention-type initiatives.
- ◆ Consider NAS trends; review areas of concern and targets of opportunity.
- ◆ Identify resourcing requirements needed in personnel, supplies, equipment, and funding for any proposed resourcing projects under the managed care support contract resource sharing agreement.
- ◆ For more information about resource sharing/resource support, contact the Managed Care Division, ext 2-6164.

5. Investment equipment/other procurement.

- ◆ Assess your current and projected major equipment acquisition's plan to support your strategy and planned service lines.
- ◆ Articulate and highlight those equipment packages to support prevention oriented initiatives and other high priority needs.
- ◆ Address the current and potential uses for telemedicine.

6. Major unfunded investment opportunities, proposals and challenges.

- ◆ Identify major financing issues and challenges.
 - ◆ Complete capabilities package for personnel, facilities, equipment, start-up, operating costs resulting from business case analysis process.
 - ◆ Population shifts due to nearby DoD facility closure realignment or service changes and rightsizing impacts in the near and long term.
- ◆ Identify procedures and tactics to fund investment opportunities as early as possible in the fiscal year to achieve maximum return on investment.

7. Information resource management.

- ◆ Assess current/projected systems' ability to support your strategy/planned service lines.
- ◆ Be aware of all inbound and outbound centrally funded systems which may affect your department as well as the timelines for implementation. Contact Healthcare Systems Support at ext. 2-5966 for more information.

8. Staff/Professional Development.

- ◆ Develop a plan to satisfy training and education programs for all assigned staff.
- ◆ Develop a CHE/CME incentive program for professional and nursing staffs.
- ◆ Address use of current technology (e.g., telemedicine, tele-education) to increase access to CME.

METRICS

Results, Performance Measures

Identify the metrics or measures you want to implement to determine if your goals and objectives are being met. Graphs are encouraged in an appendix. The QMS is a good source for data and examples.

1. Have you established metrics (e.g., HEDIS, NCQA) to help you decide if you are achieving your strategy?

- ◆ This includes meeting your milestones and metrics of technical outcome, cost, service, access, prevention, investments, etc.

HINTS:

- ◆ Measure your results on the three corners of the quality triangle (technical outcome, service, and cost).
 - ◆ Technical outcome can be measured through systems already in place such as the Maryland Hospital Indicators and the Civilian External Peer Review process and internal measurement processes required by the JCAHO such as surgical case review and drug usage evaluations.
 - ◆ Service is best measured closest to the customer. The annual Air Force Healthcare Survey is an excellent starting point. Developing your own measures of service is recommended.
 - ◆ For cost leadership, pro forma financial statements are suggested. A pro forma statement is simply a cost projection of where you will stand at a given point in the future. A quarterly spend line chart for O&M funds would meet the requirement. Other good examples are expected revenue flow from third party sources and cost per member per month/quarter listings by service category or DRG.
- ◆ Your metrics should provide benchmarks and serve as a basis for "management by fact."
 - ◆ Where applicable, each squadron/department should develop metrics and associated benchmarks for comparison of self-to-self for self improvement purposes or within established peer groupings, patient demographics and characteristics or against industry trends.
 - ◆ For example, these benchmarks or industry trends should be used to identify variation from currently established normative patterns and take the necessary actions needed for improvement. Pro forma statement development should be based on standard criteria.

2. Are you evaluating ongoing programs such as your established product lines to ensure efficiency and effectiveness?

- ◆ For evaluation purposes, standard reporting requirements should be employed and evaluation of various activities such as CHAMPUS recapture programs, workload baselines, and rightsizing activities should be ongoing.

HINTS:

- ◆ As you develop your performance measures, look at the dimensions of performance:
 - ◆ Efficacy: What was or should be the projected outcome?
 - ◆ Appropriateness: Is it relevant?
 - ◆ Availability: Did it meet patient needs?
 - ◆ Effectiveness: Was it beneficial? Necessary?
 - ◆ Continuity: Was it coordinated?
 - ◆ Safety: Did we minimize risks?
 - ◆ Efficiency: Did we use the right level of resources in the right setting?

- ◆ Respect and caring: Were we involved, sensitive?
- ◆ Continuous: Annual? Quarterly? Semi-annual?
- ◆ Health Plan Employer Data and Information Set (HEDIS) represents a core set of performance measures developed to respond to a complex, but simply-defined employer need: How to understand what "value" the health care dollar is purchasing and how to hold a health plan "accountable" for its performance. You may want to focus on the five major areas outlined by HEDIS. They are:
 - ◆ Quality.
 - ◆ Preventive Medicine: childhood immunizations, cholesterol screenings, mammography screening, cervical cancer screening, etc.
 - ◆ Prenatal Care: low birth weight, prenatal care in first trimester.
 - ◆ Acute and Chronic Disease: asthma inpatient readmission rate, diabetic retinal exam.
 - ◆ Mental Health: ambulatory follow-up after hospitalization of affective disorders.
 - ◆ Access and Patient Satisfaction.
 - ◆ Access: met and exceeded the TRICARE contract goals; percentages of members ages 23-39 and 40-64 with planned visits in previous three years and those without visits; number and percentage of primary care physicians accepting new patients; provision of plan access standards for various types of visits and telephone response; etc.
 - ◆ Member Satisfaction: met and exceeded TRICARE contract enrollment goals, percent of members who are satisfied with the plan, provision of plan satisfaction surveys.
 - ◆ Membership and Utilization.
 - ◆ Membership: enrollment/disenrollment.
 - ◆ High Occurrence/High Cost: frequency and average cost of nine DRG categories and frequency of seven selected procedures.
 - ◆ Inpatient Utilization (general hospital/acute care): medicine/surgery, maternity and newborns.
 - ◆ Ambulatory Care Utilization: outpatient visits, emergency room visits, and ambulatory surgery procedures.
 - ◆ Inpatient Utilization (non-acute care): stays in nursing homes, rehabilitation facilities, hospice, and traditional respite facilities.
 - ◆ Maternity: total deliveries subdivided by vaginal births and C-sections.
 - ◆ Newborns: well and complex newborns differentiated by LOS.
 - ◆ Mental Health: treatment on the basis of inpatient, day/night and outpatient location; readmission rates for major affective disorders.
 - ◆ Chemical Dependency: treatment on the basis of inpatient, day/night and outpatient location; readmission rates for chemical dependency.
 - ◆ Outpatient Drug Utilization: average costs and number of prescriptions per member.
 - ◆ Finance.
 - ◆ Fourteen specified performance measures address performance, liquidity, efficiency, and compliance with statutory requirements.
 - ◆ Premium trend information is also included.

3. Evaluation of major business plan proposals should be performed at set intervals using established metrics and benchmarks. You may find it easier to assess a proposal's merit by asking some or all of the following questions:

- ◆ As specifically as possible, what does this proposal contribute to health care in your community or to medical readiness requirements?
- ◆ How many people and what type of people does it benefit?
- ◆ Does the proposal benefit one group as opposed to others?

- ◆ Has the proposal's potential been fully exploited? What resources and/or marketing tools are needed to realize all anticipated benefits?
- ◆ If unable to adopt the proposal, what are the implications, both short and long term? What are the costs to using alternative sources of care if the proposal fails?
- ◆ Does the proposal provide any value towards any additional objectives?
- ◆ What is the continued demand for this service? Any room for expansion with commensurate benefits?
- ◆ Has the proposal improved the MHF's market share?
- ◆ Can this proposal (or lessons learned from it) be adapted to other MHFs?
- ◆ Is the marginal operating revenue of this proposal in excess of the marginal cost (remember costs and revenue carry nonmonetary values also especially if they involve long term impacts of health promotion and wellness efforts - i.e., consider subjective measures of cost and revenue)?
- ◆ Are there identifiable opportunity costs associated with this proposal, or other proposals or opportunities which are facilitated by this proposal? (Opportunity cost: What alternate use of these resources are we giving up by investing in this proposal?)
- ◆ Does the proposal suggest a strategic opportunity, such as a joint venture, sharing arrangement, divestiture of a major service, etc.?
- ◆ Have the operating budgets or demand patterns of other MHF services changed since this proposal was implemented?

Appendix A
GLOSSARY - INFORMATION SYSTEMS
 (Refer to MCI 37-7 for complete listing)

<u>Acronym</u>	<u>Title</u>	<u>Description</u>
ADS	Ambulatory Data System	Provides health care providers with access to automated outpatient diagnosis and treatment information down to the patient level. Summary listings can be generated.
CAPOC	Computer Assisted Processing of Cardiograms	Performs three major functions in the management of EKGs.
CDIS	CHAMPUS Detail Information System	Supports on-line, near real-time accessing and retrieval of individual detailed CHAMPUS information.
CEIS	Corporate Executive Information System	A decision support system focused on the collection, integration, Information System organization, and display of the medical information, primarily drawn from other systems, needed by MHF commanders and other managers, to make more effective management decisions.
CHCS	Composite Health Care System	CHCS is a primary source data collection system in the MHSS, providing data for the following: PAS, PAD, LAB, RAD, Clinical Dietetics, PHARM, and Nursing; CHCS creates a major portion of the electronic record data that exists today.
CIS	Clinical Information System	The patient-focused clinical arm of the managed care initiative combining the efforts of the patient-focused (Nursing) and special care management units through an interdisciplinary approach covering critical paths, and clinical case management.
CIW	Clinical Integrated Workstation	Provides a seamless integrated clinical capability within a subset of the functionality encompassed by the Provider Workstation (PWS), Ambulatory Data Collection system (ADCS), Inpatient Order Entry (IPOE), Outpatient Order Entry (OPOE), CIS, and MDIS.
CPD	Central Processing and Distribution System	Inventory control system and cart distribution operations including cost accounting.
DataStat	DataState Pharmacy System	Networked Rx system used by MHFs in San Antonio.
DMHRS	Defense Medical Human Resource System	Provides automated system support for calculating military and civilian labor time and cost for DoD health care activities.

DMLSS	Defense Medical Logistics Standard Support	Provides automated support for the management of facilities, technology, equipment, supplies, and services within MHSS in peacetime and wartime.
EMPERS III	Emergency Medical Patient Record System III	Automated registration and triage system. Provides tracking, resident procedures tracking, and nursing and physician notes.
EMTEK	Clinical Information System	Clinical Information System for ICU.
ICDB	Integrated Clinical Database	Repository of information extracted from multiple sources, providing clinical and administrative information to users in a single, inclusive database.
MEDLOG	Medical Logistics Management System	Manages accounting and inventory management for hospital supplies and inventory.
MEPRS/EAS IV	Medical Expense and EAS IV Performance Reporting System	A proposed system to provide support for standardized reporting of expenses, manpower, and workload data at the work center level within DoD Expense Assignment System, facilities Version IV
PWS	Provider Workstation	The provider interface to CHCS for placing orders; PWS is the core capability for CIW and has been absorbed into the CIW program
SPS/EPS	Space Planning System/Equipment Planning System	Provides automated estimate of the size and functional requirement for health care and medical research facilities, using DoD- established medical space planning criteria
TPOCS	Third Party Outpatient Collection System	Is a DoD standard system that assists MHFs in the collection, tracking, and reporting of data required in the outpatient insurance billing process

Appendix B
RESOURCE FORMAT EXAMPLES

Example 1:

<u>Description</u>	<u>FY 95</u>	<u>FY 96</u>	<u>FY 97 Projection</u>
604/609 - Supply			
- Total			
- Pharmacy			
- Radiology			
- Laboratory			
39X - Civ. Pay			
40X - TDY			
637 - Automation			
50X - Printing/Repro			
572 - Supplemental Care			
573 - Cooperative Care			
592 - Misc Contract Svcs			

Example 2:

MANPOWER AND PERSONNEL							
<u>AFSC</u>	<u>AUTHORIZED</u>		<u>ASSIGNED</u>		<u>PROJECTED GAINS/LOSSES</u>	<u>VACANCIES</u>	
	<u>MIL</u>	<u>CIV</u>	<u>MIL</u>	<u>CIV</u>		<u>MIL</u>	<u>CIV</u>

Example 3:

VOLUNTEER SERVICES			
<u>MONTH</u>	<u>NUMBER OF VOLUNTEERS</u>	<u>HOURS WORKED</u>	<u>FULL-TIME EQUIVALENT</u>

Example 4:

		MISSIONS				
Product	Level of Effort	Readiness	Peacetime Healthcare	GME	Research	Customer
		Manpower: Expenditures:	Manpower: Expenditures:	Manpower: Expenditures:	Manpower: Expenditures:	Manpower: Expenditures:
		Manpower: Expenditures:	Manpower: Expenditures:	Manpower: Expenditures:	Manpower: Expenditures:	Manpower: Expenditures:
		Manpower: Expenditures:	Manpower: Expenditures:	Manpower: Expenditures:	Manpower: Expenditures:	Manpower: Expenditures:
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		Manpower: Expenditures:	Manpower: Expenditures:	Manpower: Expenditures:	Manpower: Expenditures:	Manpower: Expenditures:

Manpower: How many FTEs (full-time equivalents) were (are) required to produce the specified level of effort

Expenditures: What was (is) the financial cost to produce the specified level of effort

Note: Current MEPRS data makes accurate use of Example 4 difficult. However, even a subjective breakdown into these categories will help clarify how you consume your resources.